COUNTY OF SUFFOLK

ROBERT J. GAFFNEY
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HEALTH SERVICES
Clare B. Bradley, MD, MPH
COMMISSIONER

DIVISION OF COMMUNITY MENTAL HYGIENE SERVICES
THOMAS O. MACGILVRAY, CSW, CASAC
DIRECTOR

Application For

Court-Ordered Assisted Outpatient Treatment

Referral Source _____

Relationship to Referred Party _____

Address _____

Address _____

Tel # _____ Fax # _____

Application Date: _____

- **Person Referred for AOTP:**

LAST:	FIRST:	M.I.	SEX:
ADDRESS:			
CITY:	STATE:	ZIP:	TELEPHONE:
MEDICAID#	SSN:	C# (If Known):	

- **Is this individual currently at this address? [ ] Yes [ ] No.** If not, where is this individual physically located:

ADDRESS:		
ADDRESS:		
CITY:	STATE:	ZIP:
TELEPHONE:		

- **Does this individual currently receive Case Management services? [ ] Yes [ ] No.**
  If Yes, the following section MUST be completed. ***If No, complete attached MINI-CAMERA Application.***

CASE MANAGEMENT AGENCY:	CASE MANAGER:	
ADDRESS:		
CITY:	STATE:	ZIP:
TELEPHONE:		

- **Does this individual currently receive outpatient mental health services? [ ] Yes [ ] No.**
  If Yes, the following section MUST be completed:

OUTPATIENT TREATMENT AGENCY:	THERAPIST:	
ADDRESS:		
CITY:	STATE:	ZIP:
TELEPHONE:		

Last _____ First _____ MI___

- **Does this individual currently receive outpatient alcohol or substance abuse services? [ ] Yes [ ] No.**
  If Yes, the following section MUST be completed:

OUTPATIENT TREATMENT AGENCY:		THERAPIST:
ADDRESS:		
CITY:	STATE:	ZIP:
TELEPHONE:		

- **Is this individual over the age of eighteen? [ ] Yes [ ] No.** Date of Birth _____
- **Does this individual have a diagnosed mental illness that is documented? [ ] Yes [ ] No.**
- **Does this individual have an alcohol or substance abuse diagnosis that is documented? [ ] Yes [ ] No.**

DSM-IV AXIS	DIAGNOSTIC CODE	DIAGNOSTIC DATE	DESCRIPTION
I PRIMARY			
I			
II			
II			
III			
IV			
V			

Diagnosed By: _____ Title: _____

- **Does this individual require Psychotropic Medications to maintain Stability? [ ] Yes [ ] No.**
- **Does this individual have a history of non-compliance with Psychotropic Medications? [ ] Yes [ ] No.**
- **List all treatments, including psychotropic medications, which this individual has a history of non-compliance. Include a description of timeframes and reasons for non-compliance (if known):**

Treatment Modality	Date / Timeframe of non-compliance	Reason for non-compliance.

Last _____ First _____ MI___

Describe what occurs when this person is not compliant and any precipitating factors:

Attach documentation regarding non-compliance with medications

- **Has this individual required two or more inpatient admissions to a *psychiatric* facility or forensic unit within the past 36 months? [ ] Yes [ ] No.** **(NOTE: Exclude all inpatient admission time periods from calculation of 36 months.)**

Number of Psychiatric Hospitalizations: Before1995 ____1996____1997____1998____1999____ 2000 ____

Provide a listing of ALL Psychiatric Hospitalizations listed above, Dates of admission and discharge MUST be included.

Facility	City, State	Admission and Discharge Dates	Reason for Admission

Last _____ First _____ MI___

- **Has this individual made one or more acts of, or threats of, serious violence towards self or others within the past 48 months? [ ] Yes [ ] No.** **(NOTE: Exclude all inpatient admission time periods from calculation of 48 months.)**

Provide a listing of ALL acts of violence referred to above. Dates of police or Mobile Crisis Team involvement MUST be included.

Incident or Threat Date	Against Whom & Relationship to Person for which this AOTP application is made	Description of Incident or Threat (If Police were involved, so indicate)

- **Has this individual had Detox admissions, <u>excluding psychiatric admissions</u>, within the past 36 months?**
  [ ] Yes [ ] No.

Provide a listing of ALL Detox admissions referenced above. Dates of admission and discharge MUST be included.

Facility	City, State	Admission and Discharge Dates	Reason for Admission

Last _____ First _____ MI___

- **Based upon your knowledge of the client, to what extent is this person unable to survive in the community without the assistance of the AOTP? <u>Check all categories and complete comment section below</u>.**

Area of Functioning	Severity of Impairment Rating				
	Severe	Moderate	Mild	No Problem	Unknown
Self-directed aggression					
Aggression towards others					
Self-neglect / endangerment					
Alcohol/ Drug Abuse					
Housing / Homelessness					
Financial					
Activity of Daily Living Skills					
Legal Problems					
Other: Specify					

Comments:

- **Has this individual been involved with the criminal justice system? [ ] Yes [ ] No. If Yes, describe below.**

Criminal Justice / Legal System Involvement:

Last _____ First _____ MI___

- **Is this individual currently involved with the criminal justice system? [ ] Yes [ ] No [ ] Unknown. Check the appropriate boxes and provide specifics:**

	System	Individual to whom reports are made	Telephone #
☐	Probation		
☐	Parole		
☐	Order of Protection		
☐	CPL Order		
☐	Correctional Facility		
☐	Court-Ordered Treatment		

- **Have efforts been made to mediate and/or use other methods other than AOT? [ ] Yes [ ] No Please provide specifics:**

Date of Intervention	Specific Alternative Suggested	Outcome

PLEASE ATTACH ADDITIONAL PAGES IF NEEDED

FORWARD COMPLETED APPLICATION WITH REQUIRED DOCUMENTATION
AND CURRENT CLINICAL ASSESSMENT TO:

ASSISTED OUTPATIENT TREATMENT PROGRAM
SUFFOLK COUNTY DIVISION OF COMMUNITY MENTAL HYGIENE SERVICES
225 RABRO DRIVE EAST
HAUPPAUGE, NEW YORK 11788
PHONE (516) 853-6205 FAX (516) 853-2932